Senate Committee On
HEALTH, AGING, AND LONG-TERM CARE

Select Subcommittee on Medicaid Prescription Drug Over-Prescribing

Burt L. Saunders, Chairman

Final Report and Recommendations

February 13, 2004

Report of the Health, Aging, and Long-Term Care Committee - Select Subcommittee on Medicaid Prescription Drug Over-Prescribing February 13, 2004

Background

On January 7, 2004, the Chairman of the Florida Senate Health, Aging, and Long-Term Care Committee appointed a Select Subcommittee on Medicaid Prescription Drug Over-Prescribing. Members of the Select Subcommittee were:

Senator Burt L. Saunders - Chairman
Senator Dave Aronberg
Senator Mike Fasano

The Select Subcommittee was assigned to investigate the findings and recommendations of the Seventeenth Statewide Grand Jury contained in its second interim report released December 4, 2003, and the issues raised by the Sun-Sentinel and the Orlando Sentinel in a series of articles in early December 2003 regarding the over-prescribing of narcotics that have led to numerous deaths resulting from overdose of such medications. Issues discussed in the articles included pharmacists who fill prescriptions from deceased physicians or physicians not qualified to prescribe under the Medicaid program, pharmacists who dispense excessive and inappropriate prescription drugs, physicians who over-prescribe medications to Medicaid recipients, and Medicaid recipients who "shop around" to find doctors willing to prescribe multiple medications.

Methodology

The Select Subcommittee met four times during January and February, taking testimony at three meetings in Tallahassee and one public hearing in Orlando. The subcommittee received written input before, during, and after its meetings and heard testimony from a variety of entities.

The purpose of the first meeting was to have each state entity involved in the Medicaid prescription drug over-prescribing issue, as well as the drug manufacturers, define the Medicaid over-prescribing problem from each entity's perspective. Presentations focused on prescription drug abuse, the costs of over-prescribing to the Medicaid program, and efforts to prevent the abuse of prescription drugs. The state agencies involved in the meeting included the Agency for Health Care Administration (AHCA or the Agency), the Office of the Attorney General, the Department of Health, the Office of Drug Control, and the Florida Department of Law Enforcement.

The second meeting focused on potential solutions to the prescription drug over-prescribing problem. The committee heard from the state agencies listed above, as well as the Board of Medicine, the Board of Pharmacy, the Pharmacy Association, the Florida Medical Association, the Florida Retail Federation, Purdue Pharma, and three technology companies (Gold Standard, Seisint, and U.S. Biometrics).

The public hearing in Orlando provided an opportunity for the public to present information to the subcommittee on the problem of over-prescribing of drugs under the Florida Medicaid Program. Participants included families who had lost loved ones due to Oxycontin overdoses, individuals who use Oxycontin for pain management, area physicians, and technology companies offering solutions to the over-prescribing problem.

The fourth and final meeting focused on specific statutory and funding proposals that are necessary to enhance the ongoing efforts to combat Medicaid prescription drug over-prescribing. Proposals were offered by the Agency for Health Care Administration, the Office of the Attorney General, the Department of Health, the Florida Department of Law Enforcement, the Florida Medical Association, and the Florida Board of Medicine. The Agency and the Attorney General's office also offered suggestions to changes in federal laws and regulations relating to Medicaid prescription drug over-prescribing and fraud.

Findings

Currently, Florida's Medicaid budget is $12.5 billion. The Prescribed Drug portion of this budget is $2.3 billion. The Federal government currently contributes 61.88 percent of this total for Florida (58.93 percent Federal Medicaid Assistance Percentage plus a 2.95 percent supplemental through June 2004). Florida's general revenue contribution to the Medicaid Prescribed Drug program will be approximately $877 million for the fiscal year ending June 30, 2004.

Medicaid fraud has been a high profile problem for many years. Dollars are drained off through fraud which should be used to benefit those people the program was designed to benefit. Fraud can be perpetrated by Medicaid providers, non-Medicaid providers, clinics, pharmacists, drug companies, Medicaid recipients, and industrious entrepreneurs.

In 2002, a Senate Select Subcommittee on Recovery of Medicaid Overpayments addressed a broad range of Medicaid fraud and abuse issues, which resulted in significant statutory changes and a major commitment of state resources to prevent and to prosecute Medicaid provider fraud. Florida continues to refine and implement initiatives arising from that subcommittee's work.

Agency for Health Care Administration Initiatives
Since 2002, AHCA has implemented a number of initiatives to combat Medicaid prescription drug fraud and abuse.

- In early 2002, AHCA hired five area pharmacists to meet with physicians in their offices to discuss issues such as recipient doctor shopping, coordination of care, and appropriate utilization of pain medications. AHCA is in the process of adding four more area pharmacists.

- In FY 2002-2003, AHCA implemented a Diverted Pharmaceuticals Pilot Project in Broward, Miami-Dade, Monroe, and Palm Beach counties to prevent the fraudulent practice of reselling Medicaid prescribed drugs to wholesalers and pharmacies.

- In October 2002, AHCA implemented a recipient lock-in program. This program requires that a recipient who has been identified as a high user and potential abuser of prescribed drugs, or who obtains prescriptions from multiple physicians, to obtain all of their medications from a single pharmacy. The program currently has 589 recipients enrolled, 200 of which were enrolled in the lock-in program in just the last quarter. The majority of lock-in recipients are using Oxycontin and other targeted medications. The intent is to ensure that at least one medical professional, the pharmacist, is aware of all the medications that the recipient is receiving.

- In February 2003, AHCA contracted with Heritage Information Systems to analyze and apply sophisticated drug algorithms used to detect unusual drug utilization patterns and assist AHCA in determining the cause. Prescription data are analyzed on a daily basis and summarized for AHCA on a weekly basis. Information is then disseminated to the appropriate drug utilization program for follow-up and action.

- In April 2003, AHCA began promoting the use of a website which allows the physician to view 90 days' history of all the Medicaid prescriptions filled for their patients. This allows the physician to check for abuse, compliance, and multiple prescribers.

- To further provide physicians with the necessary information to monitor their patients' drug use, in the spring of 2003, AHCA contracted with Gold Standard MultiMedia to provide 1000 handheld, wireless Personal Digital Assistants (PDAs) to the top prescribing Medicaid physicians. The PDAs provide the physician with 60 days' history of all the Medicaid prescriptions for their patients along with clinical information to assist in the appropriate prescribing of medications.

Medicaid Fraud Control Unit

Federal law requires states to establish programs designed to educate physicians and pharmacists regarding fraud, abuse, and inappropriate prescribing. In the past few years, federal and state agencies have expanded investigation and prosecution of Medicaid (and Medicare) fraud and abuse. Section 409.920, F.S., contains provisions related to Medicaid provider fraud, and requires the Attorney General to conduct a statewide program of Medicaid fraud control. The duties of the program include investigation of possible criminal violations pertaining to the administration of the Medicaid program, in the provision of medical assistance, or in the activities of Medicaid providers. The Attorney General is to investigate alleged abuse or neglect of patients in health care facilities receiving Medicaid payments, and misappropriation of patient's private funds in facilities receiving Medicaid payments, in coordination with AHCA. The Attorney General is required to refer all suspected abusive activities not of a criminal nature to the Agency, as well as each instance of overpayment which is discovered during the course of an investigation.

In addition to investigating fraud, the Medicaid Fraud Control Unit (MFCU) in the Office of the Attorney General is responsible for representing the State in prosecuting civil and criminal court actions against alleged perpetrators of Medicaid fraud. Expenditures related to MFCU activities

for the 2001-2002 fiscal year totaled $10.5 million. The Federal government reimburses the State 75 percent of MFCU costs.

MFCU completed 664 cases during the period July 2001 through January 2003 and had 395 active investigations on January 31, 2003. Of the 664 cases closed during that period, 321 (48 percent) were closed due to lack of evidence or no evidence of fraud or abuse, 175 (26 percent) resulted in convictions or settlements with total restitution of approximately $24.7 million. The remaining cases were closed due to administrative referrals, pre-trial interventions, or other reasons. Restitution payments resulting from legal settlements or court orders are collected by MFCU and the Department of Corrections and transferred to AHCA to reimburse initial overpayments.

Statewide Grand Jury Report
The Statewide Grand Jury studied the diversion of tens of millions of Medicaid dollars worth of prescription drugs by large numbers of Medicaid recipients. The Statewide Grand Jury found that there are few, if any, consequences to Medicaid recipients who sell their expensive medications to illegal drug wholesalers. According to the report,

> Efforts to deal with the problem of recipient fraud have been hampered by the lack of effective state statutes, federal limitations that restrict Florida's attempt to control this fraud, and a lack of awareness by some state and federal officials of the extent of the problem of recipient fraud. The result is the waste of hundreds of millions of dollars, exploitation of Medicaid recipients, and the tainting of our supply of critical lifesaving medication.

Accordingly, the Statewide Grand Jury further found that "the societal cost of this illicit trade in pharmaceuticals cannot be overstated."

Testimony was presented concerning Medicaid recipients selling large quantities of medicine on the streets. According to the report, one illegal wholesaler bought and sold approximately $2.4 million in Procrit, Epogen, and Panglobulin, most of which came from Medicaid recipients, in just three months.

The Statewide Grand Jury discussed the fact that the proliferation of infusion clinics has provided another way for Medicaid recipients to sell their drugs. Some infusion clinics recruit Medicaid recipients by offering them a small payment. The recipient is directed to a particular pharmacy, which then delivers the drugs in smaller doses (rather than one dose) directly to the clinic. The clinic turns around and sells the remaining doses on the black market. The pharmacy, however, bills Medicaid for all of the doses of drugs. The clinic then infuses perhaps one dose of the diluted drugs or in some instances, unbeknownst to the patient, simply infuses saline solutions into the Medicaid recipient. The clinic profits from the re-sale of the diverted drugs; and while the Medicaid recipient receives a small bribe for his or her participation, the patient is oftentimes not receiving any of the drugs that are medically appropriate. Thus, the losses are two-fold. First, some Medicaid recipients are receiving bad health care. Second, tax dollars that

could be used elsewhere are being used to pay providers and recipients for drugs that are prescribed, bought, sold, and used fraudulently.

The Statewide Grand Jury reviewed how some criminals have recruited Medicaid recipients to pretend to have AIDS by using imposters to take blood tests for them. One such Medicaid recipient received over $600,000 in AIDS medications by falsely claiming to have AIDS. In some instances, corrupt labs either exaggerate a Medicaid recipient's illness or completely falsify lab reports to come up with a phony AIDS diagnosis. Though these are often not Medicaid approved labs, Medicaid does accept lab reports from non-Medicaid labs to document the diagnosis. AHCA does not require a second opinion or follow-up lab work to verify the initial diagnosis.

The Statewide Grand Jury concluded, "while drug diversion is only part of that fraud, the other societal costs of diversion – dollars lost to the system, the exploitation of recipients, the tainting of our pharmaceuticals – leaves too much at stake for Florida taxpayers to be content to chase after the fraud. [The] Agency for Health Care Administration must make greater efforts to get ahead of this fraud and stop it before it starts. We are confident that the Legislature will recognize the seriousness of the problems that we have identified and will be supportive of Agency for Health Care Administration's efforts to address this fraud with renewed vigor." At the conclusion of the report, the Statewide Grand Jury issued a series of recommendations to the Florida Legislature and to AHCA. Many of these proposals can be accomplished under current state and federal law. Some, however, require changes to state law, while others could be realized after changes to federal law.

Governor's Taskforce

The Governor appointed a multi-agency task force to spearhead attempts to combat prescription drug abuse in early December 2003. The purpose of the taskforce was to devise an action agenda that addresses the challenges presented by the different aspects of the prescription drug abuse problem. The multi-agency taskforce was directed to address "doctor shopping and pharmacy hopping," loose internet purchases of prescription drugs, adulteration of prescription drugs, importation from abroad with no certification from the Food and Drug Administration nor oversight from US Customs, and other various allegations of illegalities such as nursing home diversions, black-market operations, and other criminal activities.

Media Reports

As discussed earlier, the South Florida Sun-Sentinel ran a series of investigative reports entitled "Drugging the Poor." According to the news articles, physicians are writing prescriptions for literally millions of dollars worth of dangerous narcotics for a few patients that are selling these drugs to street addicts and drug dealers for resale. Many Medicaid recipients go from doctor to doctor and pharmacy to pharmacy collecting incredible amounts of narcotics for this illicit trade. The results of this illegal provider and recipient activity have been highlighted recently by reports of numerous deaths resulting from drug overdoses.

Investigations focusing on pharmaceutical companies' roles, rather than provider or recipient fraud, have also been ongoing. These inquiries tend to be handled in multi-jurisdictional, judicial forums and are often centered on fraudulent marketing practices or illegal pricing activities.

Recommendations

A number of bills have already been introduced for the 2004 Session of the Legislature related to prescription drug fraud and abuse.

- Senate bill 580 - 1) creates a prescription drug monitoring system; 2) requires the Department of Health to adopt by rule the form and content of a counterfeit-resistant prescription blank for prescriptions of controlled substances listed in Schedule II, Schedule III, or Schedule IV; 3) prohibits the unlawful sale, manufacture, alteration, delivery, uttering, or possession of counterfeit-resistant prescription blanks for controlled substances; and 4) provides additional requirements for dispensing of controlled substances listed in Schedules II-IV. Senate bill 578 is a public records companion bill to SB 580.
- Senate bill 1064 is the Agency's Medicaid fraud and abuse bill, which contains a number of statutory changes that will help AHCA better combat fraud and abuse.
- Senate bill 1372 regulates "Internet pharmacy."

The subcommittee heard testimony in support of these bills during the subcommittee meetings and recommends that these bills move forward.

The Subcommittee is supportive of the following Governor's Initiatives, which include:

- Restructure Medicaid Program Integrity efforts
- Expansion of Wireless Handheld PDA Program
- Authorization of provider network controls
- Prior authorization of off-label uses of prescribed drugs
- Decrease selected prescribed drugs to 1 dose per day
- Establish therapy guidelines for selected drug categories

Each of the state agencies that appeared before the Select Subcommittee submitted written recommendations at the subcommittee's request, for statutory changes and resource needs. The detailed agency-specific proposals are attached with statutory changes and funding requests. Federal proposals are also attached. State proposals focused on the following areas:

- *Provider Lock-In* - AHCA should be able to mandate a Medicaid recipient's participation in a provider lock-in program. Programs would include but not be limited to pharmacies and physicians.

- *Disease Management* - AHCA should mandate enrollment in a disease management program if a Medicaid recipient is identified as an over-utilizer or an abuser of prescription drugs.

- *Prepayment Review* - As part of the prepayment review process, AHCA should assure that billing by a provider to the agency is in accordance with the applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law. Prepayment reviews should be conducted of claims submitted but not yet paid, as well as claims that have been processed for payment but not yet paid to the provider. Prepayment reviews should be allowed for up to one year. Timelines should be put in place related to the adjudication for denial or payment of claims both when there is reliable evidence of fraud, misrepresentation, abuse, or neglect and when there isn't.

- *Practice Patterns* - The Department of Health should be added to the Pattern Review Panel and AHCA should be given the authority to terminate a physician from the Medicaid program if the physician prescribes inappropriately or inefficiently. The Department of Health should also be allowed to investigate and discipline for bad practice patterns which aren't captured in a patient-specific case.

- *Emergency Suspension Orders* - The Department of Health should be allowed to immediately suspend a practitioner's license if the practitioner is arrested for fraudulently prescribing controlled substances to either a Medicaid or Medicare patient.

- *Pharmacy Audits* – The statutory provision giving pharmacies 1 week's notice before AHCA can conduct an audit should be deleted.

- *Payment of Medicaid Claims* - Limit the ability of non-Medicaid providers to write prescriptions that are reimbursed under the Medicaid program.

- *Medicaid Fraud Criminal Statute* - Criminal statutes for Medicaid fraud should be created. The statute should lay out the criminal penalties for: 1) selling or attempting to sell legend drugs through the Medicaid program, 2) purchasing or attempting to purchase legend drugs through the Medicaid program, and 3) making or conspiring to make false representations for the purpose of obtaining goods and services through the Medicaid program.

  The statute should also lay out the criminal penalties for a person who traffics in property paid for in whole or in part by the Medicaid program, or who finances, directs, or traffics in such property, depending on the value of the property.

  Criminal violations of ch. 409, F.S., should be added to the list of specified crimes within the jurisdiction of the statewide prosecutor and the statewide grand jury.

  Medicaid recipient fraud should be added to the definition of the term "racketeering activity."

- *Diversion Response Teams*- The Florida Department of Law Enforcement should develop seven regional Diversion Response Teams that will provide training to local law enforcement, foster public awareness about prescription fraud and abuse, collect, and

disseminate investigative and intelligence information, and coordinate law enforcement, prosecution, and regulatory action.

The proposals adopted, in concept, by the Select Subcommittee for submission to the full committee follow.

Agency for Health Care Administration
Proposals

Agency for Health Care Administration

Further Proposed Statutory Changes in Addition to SB 1064:

- Section 409.913(3), F.S. (Prepayment Review)

  The agency may conduct, or may contract for, prepayment review of provider claims to ensure cost-effective purchasing, that billing by a provider to the agency is in accordance with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law~~,~~ and ~~provision of~~ appropriate care to Medicaid recipients. Such prepayment reviews may be conducted of claims submitted but not yet paid as well as claims that have been processed for payment but not yet paid to the provider. Prepayment reviews shall be conducted as determined appropriate by the agency, without any suspicion or allegation of fraud, abuse, or neglect~~.~~, and may last for up to one year. Unless the agency has reliable evidence of fraud, misrepresentation, abuse, or neglect, claims shall be adjudicated for denial or payment within 90 days from the date complete documentation is received by the Agency for review. If there is reliable evidence of fraud, misrepresentation, abuse, or neglect, claims shall be adjudicated for denial or payment within 180 days from the date complete documentation is received by the Agency for review.

- Section 409.912, F.S. (Provider Lock-In)

  (45) The agency may mandate a recipient's participation in a provider lock-in program limiting the receipt of goods or services to a single provider. The lock-in programs shall include, but are not limited to pharmacies and physicians.

- Section 409.912(16)(b), F.S. (Prescription Pattern Review Panel)

  The responsibility of the agency under this subsection shall include the development of capabilities to identify actual and optimal practice patterns; patient and provider educational initiatives; methods for determining patient compliance with prescribed treatments; fraud, waste, and abuse prevention and detection programs; and beneficiary case management programs.

  1. The practice pattern identification program shall evaluate practitioner prescribing patterns based on national and regional practice guidelines, comparing practitioners to their peer groups. The agency and its Drug Utilization Review Board shall consult with the Department of Health and a panel of practicing health care professionals consisting of the following: the Speaker of the House of Representatives and the President of the Senate shall each appoint three physicians licensed under chapter 458 or chapter 459; and the Governor shall appoint two pharmacists licensed under chapter 465 and one dentist licensed under chapter 466 who is an oral surgeon. Terms of the panel members shall expire at the discretion of the appointing official. The panel shall begin its work by August 1, 1999, regardless of the number of appointments made by that date. The

advisory panel shall be responsible for evaluating treatment guidelines and recommending ways to incorporate their use in the practice pattern identification program. Practitioners who are prescribing inappropriately or inefficiently, as determined by the agency, may have their prescribing of certain drugs subject to prior authorization or may be terminated from all participation in the Medicaid program.

- Section 465.188, F.S. (Pharmacy Audits)

  (1) Notwithstanding any other law, when an audit of the Medicaid-related records of a pharmacy licensed under chapter 465 is conducted, such audit must be conducted as provided in this section.

  ~~(a) The agency conducting the audit must give the pharmacist at least 1 week's prior notice of the audit.~~

  The audit criteria set forth in this section shall apply only to audits of claims submitted for payment subsequent to July 11, 2003.

Budget Narrative: Waiting on this, but AHCA estimates that the additional 17 FTEs will require $1,690,478 in additional funding.

General revenue:	742,647
Administrative trust:	947,831
Total:	**1,690,478**

Governor's Initiatives:

- *Restructure Medicaid Program Integrity Efforts* – Medicaid Program Integrity (MPI) has established a separate unit dedicated to the detection and identification of abusive and aberrant billing patterns. This has resulted in a more timely and focused pursuit of fraud and abuse and more aggressive prevention activities. The long-term success in fighting fraud and abuse lies in the early detection of fraud and abuse schemes. On-site visits and focus reviews to verify data collected through the analysis of claims data are an important part of the detection process. An increase in the detection and prevention activities in the MPI field offices in Miami, Tampa, Orlando, and Jacksonville would result in a more focused and effective strategy for dealing with fraud.

- *Expansion of Wireless Handheld PDA Program* – Expansion of the wireless handheld PDA program (Gold Standard Project) is in proviso. This program has been established to enable the top 1000 prescribers to have access to the pharmacy claims history for their patients in an effort to provide them with the information needed to prevent over-prescribing. Increased funding through proviso will expand this project to the top 3000 prescribers.

- *Authorization of Provider Network Controls* – Medicaid has approximately 80,000 Fee-For-Service providers, operates an "any willing" provider enrollment process, consumes substantial resources managing such a large provider network, has more providers than needed for the beneficiary population, and foregoes savings associated with the use of its large-scale purchasing power. If Medicaid constructed its provider network like commercial insurers, substantial savings would be achieved and provider fraud and abuse would be significantly reduced. Provider enrollment would be based on need, provider accreditation, prior licensure history, quality, prior Medicaid policy compliance, Medicaid Program Integrity/Medicaid Fraud Control history, references from other payers, and participation in other payers' networks.

- *Prior Authorize Off-label Uses of Prescribed Drugs* - This proposal would require prior authorization of off-label use (non-FDA approved indication) of Neurontin, which is an anti-convulsant and indicated for neuralgia and seizures. More than 25 percent of Florida Medicaid prescribing of Neurontin is off-label. Total off-label use is approximately $10.6 million or an average of $2,400 PMPY.

- *Decrease Selected Prescribed Drugs to One Dose Per Day* - This recommendation would limit Zyprexa prescribing to one dose per day with a dosage limit of 20mg/day (FDA recommendation). Currently, prescribers are permitted to prescribe multiple small doses of a drug per day instead of a single larger dose, even if a drug is a long acting drug. Thirty percent of Florida Medicaid recipients taking Zyprexa are taking more than one dose/day; 10 percent exceed the maximum daily dose. A 2.5mg dose of Zyprexa costs $5.36/dose with 3 doses costing $16.08/day; a 7.5mg tablet is only $7.36. Florida Medicaid spends nearly $120 million on Zyprexa annually.

- *Establish Therapy Guidelines for Selected Drug Categories* - This proposal provides for the use of prescribing algorithms for major adult psychiatric disorders (schizophrenia, bipolar disorders, major depression). The successful Texas Medication Algorithm Project was implemented in 1996 and has been replicated in other states including Florida (Florida Algorithm Project – FALGO). Use of a medication algorithm will improve quality of care, promote best clinical practices, and ensure cost effective use of drugs.

Federal Statutory Barriers to Medicaid Anti-Fraud Initiatives

Medicaid Beneficiaries

Criminal and Civil Penalties for Beneficiary Fraud

Current Status

Section 1128B of the Social Security Act provides for criminal penalties for acts involving federal health care programs, and allows for suspension of Medicaid benefits for up to one year, of individuals convicted of certain federal crimes.

Federal Proposal

Amend 42 U.S.C. 1320a-7b to include that the administrator of a Federal health care program may limit, restrict, or suspend the Medicaid eligibility of individuals convicted of offenses under state law for acts involving federal health care programs, including the following: drug trafficking; trafficking in other goods and supplies paid for by Medicaid; illegal use of a Medicaid identification card; illegal transfer of a Medicaid identification card; doctor shopping for the purpose of illegally obtaining controlled substances; altering a prescription; intentionally receiving duplicative, excessive, contraindicated or conflicting health care services for personal gain; and misrepresenting symptoms or conditions to receive unnecessary medical care, goods or supplies.

Authorize imposition of fines, longer periods of suspension, and termination of Medicaid benefits for individuals convicted of offenses set forth in 42 U.S.C. 1320a-7b.

Authorize the administrator of a Federal health care program to impose fines and penalties (including restriction/suspension/termination of benefits) upon the conviction in state or federal court of an individual for acts involving federal public assistance programs.

Through federal legislation or state rulemaking, categorize types of convictions that affect Medicaid eligibility, and apply penalties as appropriate. For example, a conviction for altering a prescription could be considered a “Level 3” conviction affecting eligibility, the penalty being a restriction of benefits for a period of time deemed reasonable according to the nature of the offense. Restrictions could include denial of payment for certain classes of drugs. A conviction for illegal use of a Medicaid identification card could be considered a “Level 2” conviction affecting eligibility, the penalty being suspension of all Medicaid benefits for a reasonable period of time.

Administrative Remedies for Beneficiary Fraud

Current Status

Federal Medicaid law only authorizes criminal prosecution of beneficiary fraud, and does not authorize administrative remedies by the administering agency. This makes the process for sanctioning much more expensive and time consuming, which serves as a barrier to prosecution unless fraud cases are for very large dollar amounts.

Under federal guidelines for TANF and the Food Stamp Program, administrative remedies for beneficiary fraud currently exist. The Department of Children and Families (DCF) has hearing officers that conduct hearings on beneficiary fraud and abuse of these programs, and has a Benefit Recoveries Program that establishes overpayment receivables as a result. DCF also has program disqualification as part of the sanction/recovery process. Similar authority for administrative remedies for fraud or abuse committed by Medicaid beneficiaries would reduce the cost and resources associated with seeking sanctions or recovery through the courts system.

Federal Proposal

Amend federal legislation to authorize an administrative remedy process for Medicaid, which would allow for more coordinated action between the Agencies in taking action for beneficiary fraud and abuse, and would allow for a less costly and complex process for levying sanctions.

Through federal legislation or state rulemaking, allow imposition of the following sanctions:

- Restriction of certain benefits
- Suspension of benefits
- Termination of benefits
- Restitution
- Fines

Restriction of Freedom of Choice of Providers

Current Status

Under Section 1915(a) of the Social Security Act, and Title 42 Code of Federal Regulations 431.54, states are permitted to enroll beneficiaries suspected of fraud/abuse/misuse of benefits into a pharmacy or physician lock-in program. However, 1902(a)(23) of the Social Security Act provides that Medicaid eligible beneficiaries must be allowed to obtain benefits from any willing and qualified provider. Notwithstanding the provisions in 1915(a), waiver of this section is permitted through 1915(b) of the

Social Security Act; however, the waiver process is burdensome, both on time and resources.

Proposal

Amend federal legislation to grant broader authority to states to limit Medicaid beneficiaries' freedom of choice of providers to preferred/enrolled providers, and to expand a state's ability to limit provider networks through expedition or elimination of the 1915(b) waiver process.

Medicaid Providers

Any Willing Provider

Current Status

Section 1902(a)(23) of the Social Security Act provides that beneficiaries may obtain services from any qualified Medicaid provider that undertakes to provide the services to them. Specifically, subsection 23 states that a State plan for medical assistance must provide that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services . . . except that nothing in this paragraph shall be construed as requiring a State to provide medical assistance for such services furnished by a person or entity convicted of a felony under Federal or State law for an offense which the State agency determines is inconsistent with the best interests of beneficiaries under the State plan. See also 42 C.F.R. 431.51(b).

However, there is an exception to the general freedom of choice rule. 42 U.S.C. 1396n provides that a State shall not be found out of compliance with 1396a solely because the State imposes certain specified allowable restrictions on freedom of choice. In addition, federal regulations provide that states may interfere with a beneficiary's freedom of choice by "[s]etting reasonable standards relating to the qualifications of providers." 42 C.F.R. 431.51(c)(2). Some of the reasons for restricting provider enrollment that may be deemed reasonable include (1) the protection of beneficiaries by allowing the state to exercise some degree of control over providers, (2) assisting the state in properly allocating scarce public resources, (3) preventing fraud, and (4) promoting good service. See Nutritional Support Services v. Miller, 806 F.Supp. 977, 979 (N.D. Ga. 1992); Macombs Pharmacy, Inc. v. Wing, 1998 U.S. Dist. Lexis 15664 (S.D. N.Y. 1998) (court held that denying an applicant enrollment in the Medicaid program on the grounds that there was no need for an additional provider in the geographical area in which the applicant was located was rationally related to the legitimate government interests of preventing fraud and promoting good services).

In addition, courts have concluded that Section 1902(a)(23) does not create a right of action for providers. See, e.g., Silver v. Baggiano, 804 F.2d 1211, 1215 (11th Cir. 1986) (court held that "there is no indication in the language [of the Act] that health care practitioners are given any rights by this provision"); Catanzano v. Wing, 992 F.Supp. 593, 595 (W.D. N.Y. 1998)(1902(a)(23) was "intended to confer rights upon health care beneficiaries, not providers"); Nutritional Support Services v. Miller, 826 F.Supp. 467, 470 (N.D. Ga. 1993)(court concluded that durable medical equipment providers could not assert a § 1983 claim for violation of 1902(a)(23)).

Although courts have interpreted 1902(a)(23) of the Social Security Act in various ways, the language of the current federal statutes limits states' options in restricting willing and qualified providers from participating in Medicaid. 1915(b) of the Social Security Act allows for waiver of 1902(a)(23) through a formal application process, which is often burdensome and costly to states.

Federal Proposal

Modify 1902(a)(23) "Any Willing, Qualified Provider" provisions, and other pertinent provisions of the Social Security Act, to clarify states' rights in the area of provider network controls. Expand states' ability to limit provider networks through expedition or elimination of the 1915(b) waiver process.

Provider Over-Payments

Current Status

42 CFR 433.316(d) states that "An overpayment that results from fraud or abuse is discovered (and therefore reported to the federal Centers for Medicare and Medicaid Services, or CMS) on the date of the final written notice of the State's overpayment determination that a Medicaid agency official or other State official sends to the provider." The result of this has been that the Agency is required to record billings to providers upon issuance of a Final Audit letter, and to refund the federal portion of the amount owed by the provider prior to the appellate process.

Collecting debts owed to the state is a difficult process. For various reasons (bankruptcy, refusal to pay, and imprisonment of debtor) the amount billed on the Final Audit letter may not be collected. Additionally, the amount due may be reduced by the Appellate process.

Proposal

Revise federal legislation to allow for the recording and refunding of the overpayment at the time all appellate and collection efforts are exhausted. This would require changing the Code of Federal Regulations reporting requirements from "date of final written notice" to "the date of the final notice of amount due that a Medicaid agency or other

State official sends to the provider in which no appeal is pending or after resolution of the appellate proceeding."

Bankruptcy

Current Status

- Medicaid overpayment claims are unsecured claims in the bankruptcy of a provider. [11 U.S.C. §§ 101(5), 506]
- Medicaid overpayment claims are not granted a priority over the claims of other creditors. [11 U.S.C. § 507]
- Whether the case is a Chapter 7 liquidation, Chapter 11 reorganization, or Chapter 13 individual payment plan, Medicaid only receives a pro rata share of the distribution to general unsecured creditors. [11 U.S.C. §§ 726, 1129, 1325]
- In bankruptcies under Chapters 7 or 11, a bankrupt Medicaid provider may not discharge liability for Medicaid overpayments obtained by fraud, false pretenses, false representation, or larceny. [11 U.S.C. §523(a)(2), (4)] However, to enforce these exceptions to discharge the State would have to bring a separate suit against the debtor in the bankruptcy court, waiving the State's sovereign immunity on these issues.
- Debtors may discharge liability for Medicaid overpayments obtained by fraud in Chapter 13 individual payment plans, except for those restitution liabilities imposed by a criminal conviction. [11 U.S.C. §1328]

Proposal to Improve Recovery of Medicaid Overpayments from Bankrupt Providers

- State law: Require the provider to grant a lien in property to secure obligation to repay overpayments. This would make the State a secured bankruptcy creditor.
- Create an exception to discharge under 11 U.S.C. §523 providing that Medicaid overpayments determined in State civil, criminal, or administrative proceedings may not be discharged under 11 U.S.C. §§ 727 and 1141, and must be paid in full for a debtor to receive a discharge in a Chapter 13 case.
- Modify the automatic stay under 11 U.S.C. §362 to allow the State to pursue proceedings to adjudicate the amount of a Medicaid overpayment but not permitting collection of the overpayment other than by State law recoupment.
- Modify the automatic stay under 11 U.S.C. §362 to acknowledge the rights of Medicare and the state Medicaid programs to recoup overpayments against current and future payments.
- Modify 11 U.S.C. §507 by giving state Medicaid overpayments at least an eighth priority (above unpaid taxes) in payment. This will require payment in full or satisfactory treatment of all Medicaid overpayments claims prior to any payment to general unsecured creditors.

General

Data Sharing

Current Status

An agreement is currently in place under which CMS will conduct a computer matching program with the State of Florida, Agency for Health Care Administration (AHCA) to study claims, billing, and eligibility information to detect suspected instances of Medicare and Medicaid fraud and abuse (F&A) in the State of Florida. CMS and AHCA will provide TriCenturion, a CMS contractor for the Medicare and Medicaid programs, records pertaining to eligibility, claims, and billing which TriCenturion will match in order to merge the information into a single database. Utilizing fraud detection software, the information will then be used to identify patterns of aberrant practices requiring further investigation.

Proposal

Florida is one of six states to participate in this matching program and this contract is in effect for 18 months after the execution, expected to be in April 2004. The Agency believes that this national project should be made permanent and extended to all states to assist in identifying duplicate payments, duplicate services and much more.

Federal Funding

Current Status

Currently, Medicaid Program Integrity functions receive approximately 50% federal matching funds.

Proposal

Federal matching for Medicaid Program Integrity (MPI) functions should be increased to 90% federal matching for MPI system and other development activities, and 75% federal matching for MPI operations. The Medicaid Fraud Control Unit (MFCU) in the Office of the Attorney General currently receives an enhanced federal match (75-90%) for its fraud functions. By increasing the federal matching funds to align with that of MFCU, MPI would be able to increase its investigative abilities and resources to monitor aberrant billings and look at possible fraud and abuse in more detail.

Office of the Attorney General
Proposals

Office of the Attorney General

Proposed Statutory Changes in Bill Draft #37-1161-04 Addressing the Recommendations of the Statewide Grand Jury:

Section 1. **Creates s. 409.9201 Medicaid Fraud**
(1) Defines "Legend drug" and "Value";
(2) Provides that a person who sells, attempts, conspires or causes another to sell commits a felony; and sets felony degree based on value of legend drugs;
(3) Provides for aggregated penalties; and
(4) Provides that a person who makes, causes, conspires, or attempts to make false representation for the purpose of obtaining goods from Medicaid commits a felony.

Section 2. **Creates s. 812.0191 Dealing in property paid for in whole or in part by the Medicaid program**
(1) Defines "Property paid for in whole in part by the Medicaid program" and "Value";
(2) Provides that any person who traffics in property paid by Medicaid program commits a felony; and
(3) Any person who initiates, organizes, plans, finances, etc. the obtaining of property commits a first degree felony.

Section 3. **Amends s. 16.56 Office of Statewide Prosecution**
Provides that the Office of Statewide prosecution may investigate and prosecute: any criminal violation of chapter 409.

Section 4. **Amends s. 409.912 Cost-effective purchasing of health care**
Paragraph (a), subsection (40)
Provides mandatory enrollment in drug-therapy program for all Medicaid recipients identified as abusers or over-users.

Section 5. **Amends s. 409.913 Oversight of the integrity of the Medicaid program**
Subsection (7) (b)
Prohibits physicians who are not authorized Medicaid providers, except in bona fide emergency, from prescribing medications, supplies, services to a Medicaid recipient when the physician know or should know that a claim for reimbursement will be submitted.

Prohibits a vendor, except in a bona fide emergency, from submitting claims when the vendor knows or should have known the physician prescribing is not an authorized Medicaid provider.

Provides that any person who knowingly violates this chapter shall reimburse the Medicaid program for the full amount of each claim submitted in violation of this chapter and shall be subject to penalties, investigation costs and attorney's fees.

Provides that the agency may not reimburse a person for any Medicaid claim that does not meet all of the criteria in this subsection.

Section 6. **Amends s. 895.02 Definitions**
Expands definition of "Racketeering activity" to include crimes under s. 409.9201, relating to Medicaid recipient fraud.

Section 7. **Amends s. 905.34 Powers and duties; law applicable**
Provides that the Statewide Grand Jury's jurisdiction includes: Any criminal violation of chapter 409.

Section 8. **Provides an effective date**
July 1, 2004

Additional Proposed Amendment language to Bill Draft # 37-1161-04:

- On Page 2, line 20, a new Section One is added to the bill, amending paragraph (i) of subsection (1), of Section 400.408 to read as follows:

(i) Each field office of the Agency for Health Care Administration shall establish a local coordinating workgroup which includes representatives of local law enforcement agencies, state attorneys, the Medicaid Fraud Control Unit of the Department of Legal Affairs, local fire authorities, the Department of Children and Family Services, the district long-term care ombudsman council, and the district human rights advocacy committee to assist in identifying the operation of unlicensed facilities and to develop and implement a plan to ensure effective enforcement of state laws relating to such facilities. The workgroup shall report its findings, actions, and recommendations semiannually to the Director of Health Facility Regulation of the agency.

- Page xx, line xx, a new Section Two is added to the bill, amending Section 400.434, Florida Statutes to read as follows:

Right of entry and inspection. – Any duly designated officer or employee of the department, the Department of Children and Family Services, the agency, the Medicaid Fraud Control Unit of the Department of Legal Affairs, the state or local fire marshal, or a member of the state or local long-term care ombudsman council shall have the right to enter unannounced upon and into the premises of any facility licensed pursuant to this part in order to determine the state of compliance with the provisions of this part and of rules or standards in force pursuant thereto....

- On Page xx, line xx, a new Section Three is added to the bill, amending subsection (14) of Section 409.908, Florida Statutes, creating new paragraphs (a) and (b) and renumbering existing language as paragraph (c), to read as follows:

(a) A provider of prescribed drugs shall not be reimbursed for drugs provided to Medicaid recipients pursuant to a prescription from a medical practitioner ~~previously terminated from the Medicaid program, or~~ who is not a Medicaid provider. Providers of prescribed drugs shall determine whether the prescribing practitioner is a Medicaid provider prior to filling or dispensing any prescribed drug to a Medicaid recipient. The agency shall not reimburse any person or entity for any prescription for medications, medical supplies, or medical services when such prescription was written by a physician or other medical provider who is not an authorized Medicaid provider. This section shall not apply in instances involving bona fide emergency medical conditions as defined in s. 395.02 (9) or to prescribing physicians who are board certified specialists treating Medicaid recipients referred for treatment as provided in FS xx.xx by a treating physician who is an authorized Medicaid provider or to prescriptions written for dually eligible Medicare beneficiaries and Medicaid recipients by an authorized Medicare provider who is not an authorized Medicaid provider.

(b) The Agency for Healthcare Administration shall insure that the pharmacology drug information system initiative set forth in Section 409.912(14)(b)(4), Fla. Stat., or other data system as appropriate, includes information allowing a provider of prescribed drugs to determine whether a prescribing practitioner is or is not a Medicaid provider.

(c) Subject to the provisions of paragraph (a) of this section, ~~A~~ a provider ...

(d) Any person or entity who knowingly violates this statute or knowingly participates in a plan or scheme to cause others to violate this statute, shall be required to reimburse the Florida Medicaid program for the full amount of the Medicaid claim(s) submitted in violation of this statute, and will be subject to penalties equal to three times the amount of the unlawful Medicaid claim(s) submitted, along with civil monetary assessments of up to $5,000 for each Medicaid

claim submitted for medications, medical equipment or medical services in violation of this statute, as well as investigation and prosecution costs and attorney fees. The remedies set forth in this statute shall not be exclusive, but rather, in addition to all other available remedies.

- On Page xx, Line xx, a new Section Four is added to the bill, amending the first paragraph of Section 409.912, to read as follows:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, in any case the agency may require a second physician's confirmation or opinion of the correct diagnosis before authorizing payment for medical treatment. Such confirmation or second opinion shall be rendered only by a physician chosen by the agency to do so in the particular case. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency may establish prior authorization requirements for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization.

- On Page xx, line xx, a new Section Five is added to the bill, creating a new subsection (45) to Section 409.912, Florida Statutes to read as follows:

(45) The agency may mandate a recipient's participation in a provider lock-in program limiting the receipt of goods or services to a single specified provider. The lock-in programs shall include, but are not limited to, pharmacies and physicians, as specified by the agency.

- On Page 15, line 19 to Page 16, line 16, the provisions of existing Bill Section 5 that were numbered as subparagraphs (b) 1., (b) 2., and (b)3., are removed from the new draft as follows:
~~(g) Except in instances involving bona fide emergencies, physicians who are not authorized Medicaid Providers shall not prescribe medications, medical supplies or medical services to Medicaid recipients when such non-Medicaid physicians know or should know that a claim for reimbursement of any portion of the cost of the prescribed medications, medical supplies or medical services will be submitted to the Florida Medicaid program. Likewise, except in instances involving bona fide emergencies, health care vendors of prescription medications, medical supplies or medical services, otherwise authorized to submit claims for Medicaid reimbursements, shall not submit claims for Medicaid reimbursements when such health care vendors know or should know the physician prescribing the medications, medical supplies or medical services is not an authorized Medicaid provider. Any person or entity who knowingly violates this statute or knowingly participates in a plan or scheme to cause others to violate this statute, shall be required to reimburse the Florida Medicaid program for the full amount of the Medicaid claim(s) submitted in violation of this statute, and will be subject to penalties equal to three times the amount of the unlawful Medicaid claim(s) submitted, along with civil monetary assessments of up to $5,000 for each Medicaid claim submitted for medications, medical equipment or medical services in violation of this statute, as well as investigation and prosecution costs and attorney fees. The remedies set forth in this statute shall not be exclusive,~~

~~but rather, in addition to all other available remedies.~~

~~(h) Paragraph (g) of this section shall not apply to prescriptions written by board certified specialists treating a Medicaid recipient referred for treatment by the Medicaid recipient's treating physician whose prescriptions are otherwise permitted to be reimbursed by Medicaid or prescriptions written for a dually eligible Medicare beneficiary and Medicaid recipient by an authorized Medicare provider.~~

- On Page 16, line 17, a new Section Six is added to the bill, creating a new paragraph (g) to subsection (7) of Section 409.913, Florida Statutes , [the provision of Existing Bill Section Five that is presently numbered in that draft as (7)(c) is renumbered as (7)(g)] to read as follows:

(g) The agency may not reimburse a person for any Medicaid claim that does not meet all of the criteria in this subsection.

- On Page 16, line 20, a new Section Seven is added to the bill, amending subsection (28) of Section 409.913, Florida Statutes, to read as follows:

(28) Notwithstanding any other provision of law, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs may review a provider's non-Medicaid-related records in order to determine the total output of a provider's practice to reconcile quantities of goods or services billed to Medicaid with ~~against~~ quantities of goods and services used in the provider's total practice.

- On Page 16, line 20 (or as soon thereafter as is practicable), a new Section Eight is added to the bill, creating a new subsection (32) of Section 409.913, Florida Statutes, to read as follows:

(32) To deter fraud and abuse in the Medicaid program, the agency shall have the authority to limit the number of Schedule II and Schedule III refill prescription claims submitted from pharmacy providers. The agency shall limit the allowable amount of reimbursement of prescription refill claims if the agency or the Medicaid Fraud Control Unit determines that the specific prescription refill~~s are~~ was not requested by the Medicaid recipients for whom the refill claim is submitted, or ~~were~~ was not prescribed by the recipient's medical provider or physician. Any such refill request must be consistent with the original prescription.

- On Page 16, line 20 (or as soon thereafter as is practicable), a new Section Nine is added to the bill, creating a new subsection (6) of Section 409.9131, Florida Statutes, to read as follows:

(6) For any Medicaid provider submitting a cost report to the agency by any method, and in addition to any other certification, the following statement must immediately precede the dated signature of the provider's administrator or chief financial officer on such cost report:

> "I certify that I am familiar with the laws and regulations regarding the provision of health care services under the Florida Medicaid Program, including the laws and regulations relating to claims for Medicaid reimbursements and payments, and that the services identified in this cost report were provided in compliance with such laws and regulations."

– On Page 3, line 4, in existing Section One, [now renumbered as Section Ten] of the bill, after, "person who", insert "knowingly".

– On Page 3, line 4, in existing Section One, [now renumbered as Section Ten] of the bill, after, "sells, who", insert "knowingly".

– On Page 3, line 5, in existing Section One, [now renumbered as Section Ten] of the bill, after, "or who", insert "knowingly".

– On Page 3, line 25, in existing Section One, [now renumbered as Section Ten] of the bill, after, "person who", insert "knowingly".
– On Page 3, line 25, in existing Section One, [now renumbered as Section Ten] of the bill, after, "purchases, or", insert "who knowingly".

– On Page 4, line 8, in existing Section One, [now renumbered as Section Ten] of the bill, after, "person who", insert "knowingly".

– On Page 4, line 8, in existing Section One, [now renumbered as Section Ten] of the bill, after, "or who", insert "knowingly".
– On Page 5, line 27, in existing Section One, [now renumbered as Section Ten] of the bill, after "person who", insert "knowingly".

– On Page 3, Line 4, in existing Section One [now renumbered as Section Ten] of the bill, a new subsection (4) of Section 409.9201, Florida Statutes, is created, to read:

Property "paid for" shall include all property furnished to or intended to be furnished to any recipient of benefits under the Medicaid program, regardless of whether reimbursement is ever actually made by the program.

– On Page 16, line 20 (or as soon thereafter as is practicable), a new Section Eleven is added to the bill, creating a new subsection (g) in Section 409.920, Florida Statutes, to read as follows:

(g) Knowingly use or endeavor to use a Medicaid provider's identification number or a Medicaid recipient's identification number to make, cause to be made, or aid and abet in the making of a claim for items or services that are not authorized to be reimbursed by the Medicaid program.

– On page 16, line 20 (or as soon thereafter as practicable), a new Section Twelve is added to the bill, amending paragraph (a) of subsection (8) of Section 409.920, to read as follows:

(a) Enter upon the premises of any health care provider, excluding a physician, participating in the Medicaid program to examine all accounts and records that may, in any manner, be relevant in determining the existence of fraud in the Medicaid program, to investigate alleged abuse or neglect of patients, or to investigate alleged misappropriation of patients' private funds. A participating physician is required to make available any accounts or records that may, in any manner, be relevant in determining the existence of fraud in the Medicaid program, to investigate alleged abuse or neglect of patients, or to investigate alleged misappropriation of patients' private funds. Subject only to applicable Federal Statutes, ~~and Florida Statutes including section 397.501(7)(k),~~ but notwithstanding any other provision of law, the accounts or records of a non-Medicaid patient may be reviewed by the Medicaid Fraud Control Unit, without the patient's consent, pursuant to an investigation of suspected Medicaid fraud in or to determine consistency in the quality and appropriateness of treatment provided to Medicaid recipients as compared to non-Medicaid recipients . Moreover, the Medicaid Fraud Control Unit may review in existing Section One, [now renumbered as Section XX] of the bill, accounts or records of non-Medicaid patients pursuant to an investigation of suspected patient abuse, neglect or misappropriation of private funds relating to such non-Medicaid patient, without the patient's consent. ~~not be reviewed by, or turned over to, the Attorney General without the patient's written consent.~~

– On Page 21, line 6 (or as soon thereafter as practicable) a new Section Thirteen is added to the bill, creating a new subparagraph 10. of subsection (a) of Section 932.701, Florida Statutes, to read as follows:

10. Any real property, including any right, title, leasehold, or other interest in the whole of any lot or tract of land, which is acquired by proceeds obtained as a result of Medicaid Provider Fraud, s.409.920. or any personal property, including, but not limited to, equipment, money, securities, books, records, research, negotiable instruments, currency, or any vessel, aircraft, item, object, tool, substance, device, weapon, machine, or vehicle of any kind in the possession of or belonging to any person which is acquired by proceeds obtained as a result of Medicaid Provider Fraud, s.409.920.

– On Page 21, line 6 (or as soon thereafter as may be practicable), a new Section Fourteen is added to the bill, creating a new paragraph (l) of subsection (5) of Section 932.7055 to read as follows:

(l) The Department of Legal Affairs, Medicaid Fraud Control Unit, the proceeds accrued pursuant to the provisions of the Florida Contraband Forfeiture Act shall be deposited into the Grants and Donations Trust Fund as provided in s.409.916, as applicable.

- On Page __, line __ (or as soon thereafter as may be practicable), a new Section Fifteen is added to the bill, amending s.409.920(1)(d) as follows:

(d) "Knowingly" means ~~done by a person who is aware or should be aware of the nature of his or her conduct and that his or her conduct is substantially certain to cause the intended result.~~ that the act was done voluntarily and intentionally and not because of mistake or accident. As used in this section, "knowingly" also includes the word "willfully" or "willful" which, as used in this section, means that an act was committed voluntarily and purposely, with the specific intent to do something the law forbids; that is with bad purpose either to disobey or disregard the law.

Florida Department of Health
Proposals

Florida Department of Health

Proposed Statutory Changes:

1) Create s. 456.072(1)(ff), Florida Statutes:

> 456.072(1)(ff) Engaging in a practice pattern which demonstrates a lack of reasonable skill and safety to patients, a violation of any provision of this chapter, a violation the applicable practice act, or a violation of any rules adopted pursuant thereto.

This would allow the Department of Health to investigate and discipline for bad practice patterns which aren't captured in a patient-specific case.

2) By legislative resolution, encourage the US Congress to enact laws requiring a warning on all advertising for prescription drugs that without an appropriate prescription and prescriber/patient relationship, on-line prescribing may be illegal and harmful to your health.

Funding Request

The Department needs 2 Senior Attorneys-PG 230 (PSU) and 2 Administrative Secretaries SES PG 412 (PSU) to handle emergency actions and prosecution of practitioners who are inappropriately prescribing drugs. These can be funded from the MQA trust fund so the department just needs budget authority.

Florida Department of Law Enforcement
Proposals

COMBATING PHARMACEUTICAL DRUG ABUSE AND FRAUD - FLORIDA'S REGIONAL DIVERSION RESPONSE TEAMS

LAW ENFORCEMENT SOLUTIONS:

- Improve training and public awareness
- Develop a sustained commitment
- Synchronize criminal enforcement and regulatory actions
- Improve information exchange

PROPOSED DIVERSION RESPONSE TEAMS:

Seven regional Diversion Response Teams (DRT) would be created, utilizing a multi-disciplinary approach, including members from state and federal agencies. DRTs would:

- Coordinate criminal enforcement, prosecution, and regulatory activities among agencies (with no impact on current jurisdictional investigative authority or responsibilities)
- Ensure regional training for multiple disciplines
- Assist in public awareness and education campaigns
- Ensure collection and dissemination of investigative/intelligence information
- Meet regularly and prepare briefings for the Prescription Drug Task Force

SHORT-TERM GOALS:

- Communicate each agency's responsibilities, authority, and procedures
- Provide assessment on criminal investigative progress and regulatory enforcement strategy
- Establish a personal communications network

LONG-TERM GOALS:

- Identify and prosecute pharmaceutical diversion cases
- Provide a report to the Prescription Drug Task Force regarding progress and limitations
- Establish a formal communications network

RESOURCE NEEDS:

- 1 Special Agent Supervisor (provide statewide coordination of FDLE resources) $115,779
- 8 Special Agents (one in each region, 2 in Miami) $858,621
- 1 Government Analyst (intelligence analysis and case support) $64,760
- Total: 10 FTEs and $1,039,159 (figure includes salaries, benefits, and expense package)

Florida Medical Association
Proposals

FLORIDA MEDICAL ASSOCIATION, INC.

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TO: Senator Burt Saunders, Chairman
Senate Select Committee on Medicaid Prescription Drug Overprescribing

FROM: Francesca Plendl, Director of Governmental Affairs
Florida Medical Association

DATE: January 23, 2004

RE: Senate Bill 1064

The Florida Medical Association has reviewed Senate Bill 1064, which makes changes to the Medicaid laws which are both substantive and substantial. We support efforts to control fraud within the Medicaid system while at the same time ensuring that patients in Florida continue to receive quality care and treatment. We believe the following changes to the bill will meet both of these goals:

1. Within Section 2 of the bill, on page 10, lines 8-19, a paragraph (g) is being added to Section 409.913(7), Florida Statutes. The current language in the bill would prohibit a Medicaid patient from receiving care or a prescription from a non-Medicaid provider. This would prohibit a physician who is not in the Medicaid program from seeing a patient pro bono or from seeing patients who are dual eligibles (eligible for both Medicaid and Medicare benefits). The FMA suggests that the below language be used instead:

Delete lines 8-13 on page 10 and insert the following:
(g)(1) Are authorized by a Medicaid provider;
(2) For medically necessary medications prescribed by a physician licensed pursuant to Chapter 458 or Chapter 459 to a Medicaid recipient whom the physician has treated without compensation;
(3) For medically necessary medications prescribed by a physician licensed pursuant to Chapter 458 or Chapter 459 to a patient who is eligible to receive services from both Medicaid and Medicare; or
(4) Are otherwise authorized by the Medicaid program.

This language will allow a non-Medicaid physician who treats a patient on a pro bono basis or who treats Medicare patients who qualify for prescription drugs from Medicaid to continue to prescribe medically necessary drugs to those patients. This language still meets AHCA's goal of prohibiting most non-Medicaid physicians from prescribing to Medicaid patients without restriction.

Please note that the FMA has been unable to determine what lines 15-19 on page 10 state, but it appears that these lines may need to be reworded.

2. Within Section 2 of the bill, on page 12, lines 1-8-19, paragraph (h) of Section 409.913(14), Florida Statutes is being altered so that the Medicaid program would be able to seek action against a provider who submits even one erroneous Medicaid claim. The current law requires that the claim either be false or that a *pattern* of erroneous claims be shown. The FMA is asking that the words "a pattern of" *not* be stricken. Taking action against or prosecuting a provider for just one erroneous claim will result in unnecessary actions by AHCA and will keep good providers out of the Medicaid system. This change in the law does not help to deter fraud and will result in a reduction in the provision of quality health care for Medicaid patients. This language should not be stricken from the current law.

3. Within Section 2 of the bill, on page 16, line 1, paragraph 24(a) of Section 409.913(14), Florida Statutes is being altered so that the Medicaid program would be able to withhold Medicaid payments from a provider indefinitely. Currently this may only be done "pending completion of legal proceedings." The bill proposes to strike the words "pending completion of legal proceedings." This is simply draconian and should not be part of this bill. Again, this change in the law does not help to deter fraud and will result in a reduction in the provision of quality health care for Medicaid patients. This proposal should be taken out of this bill.

4. Within Section 3 of the bill, on page 17, lines 17-31, paragraphs (2) and (5) of Section 409.9131, Florida Statutes is being altered so that peer review in the Medicaid program, which helps to ensure the integrity of the program by providing for medical expertise and review, would (a) no longer include the determination of whether the documentation in the physician's records is adequate – AHCA staff would be able to make this determination without input from an appropriate medical professional and (b) would require that physician peer review be limited to a review of: medical necessity, appropriateness and quality of care - currently, peer review of physician claims is not limited to only those determinations.

Peer review prior the initiation of formal proceedings by AHCA is a hard won benefit for Medicaid providers. It is an important part of the due process that has been granted to providers and taking a substantial part of this away will impact on good providers staying in the Medicaid program which ultimately hurts only patients. This change in the law will not help to deter fraud and will negatively impact patients.

FLORIDA MEDICAL ASSOCIATION, INC.

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TO: Senator Burt Saunders, Chairman
Senate Select Committee on Medicaid Prescription Drug Overprescribing

FROM: Francesca Plendl, Director of Governmental Affairs
Florida Medical Association

DATE: January 23, 2004

RE: Emergency Suspension Orders

During meetings of the Senate Select Committee on Medicaid Prescription Drug Overprescribing, the idea has been discussed to increase the power of the Department of Health in regards to the issuance of Emergency Suspension Orders, specifically when a practitioner is arrested for Medicaid fraud. The Florida Medical Association has examined this issue closely, and would like to make the proposal set forth below. We support efforts to control fraud within the Medicaid system while at the same time ensuring that practitioners' due process rights are observed. In addition, it is important to ensure that the Department of Health is not unduly restricted as it proceeds with action against the practitioner's license.

The language suggested below amends Section 456.074, Florida Statutes, entitled Certain Health Care Practitioners; Immediate Suspension of License. The language below *adds a provision to this statute* that will allow the Department of Health to immediately suspend a practitioner's license if the practitioner is arrested for fraudulently prescribing controlled substances to either a Medicaid or Medicare patient. At the same time, the proposal:
1. Allows the Department of Health to make the determination as to whether it has enough evidence to proceed with the licensure action, by using the word "may" rather than "shall". If the word "shall" is used, it will force the Department of Health to, in some cases, proceed to hearing before it is ready to prove its case, thereby ensuring a not guilty verdict at the Division of Administrative Hearings.
2. Mirrors language already set forth in Section 456.074, Florida Statutes, regarding what practitioners are covered and what statutes are involved.

The proposed change is as follows:

456.074 Certain health care practitioners; immediate suspension of license.—

(1) The department shall issue an emergency order suspending the license of any person licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 464, chapter 465, chapter 466, or chapter 484 who pleads guilty to, is convicted or found guilty of, or who enters a plea of nolo contendere to, regardless of adjudication, a felony under

chapter 409, chapter 817, or chapter 893 or under 21 U.S.C. ss. 801-970 or under 42 U.S.C. ss. 1395-1396.

(2) If the board has previously found any physician or osteopathic physician in violation of the provisions of s. 458.331(1)(t) or s. 459.015(1)(x), in regard to her or his treatment of three or more patients, and the probable cause panel of the board finds probable cause of an additional violation of that section, then the Secretary of Health shall review the matter to determine if an emergency suspension or restriction order is warranted. Nothing in this section shall be construed so as to limit the authority of the secretary of the department to issue an emergency order.

(3) The department may issue an emergency order suspending or restricting the license of any health care practitioner as defined in s. 456.001(4) who tests positive for any drug on any government or private-sector preemployment or employer-ordered confirmed drug test, as defined in s. 112.0455, when the practitioner does not have a lawful prescription and legitimate medical reason for using such drug. The practitioner shall be given 48 hours from the time of notification to the practitioner of the confirmed test result to produce a lawful prescription for the drug before an emergency order is issued.

(4) Upon receipt of information that a Florida-licensed health care practitioner has defaulted on a student loan issued or guaranteed by the state or the Federal Government, the department shall notify the licensee by certified mail that he or she shall be subject to immediate suspension of license unless, within 45 days after the date of mailing, the licensee provides proof that new payment terms have been agreed upon by all parties to the loan. The department shall issue an emergency order suspending the license of any licensee who, after 45 days following the date of mailing from the department, has failed to provide such proof. Production of such proof shall not prohibit the department from proceeding with disciplinary action against the licensee pursuant to s. 456.073.

(5) The department may issue an emergency order suspending the license of any person licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 464, chapter 465, chapter 466, or chapter 484 who is arrested for a felony under chapter 409, chapter 817, or chapter 893 or under 21 U.S.C. ss. 801-970 or under 42 U.S.C. ss. 1395-1396 if the allegations in the case include fraudulent prescribing of controlled substances (as defined in Chapter 893) to a Medicaid or Medicare patient for monetary gain by the licensee.